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Lobotomy in Norwegian psychiatry

JOAR TRANØY*
Municipality of Oslo

WENCHE BLOMBERG
University of Oslo

Lobotomy is still a hidden chapter in the history of Norwegian psychiatry. The main reasons, which are discussed here, may have been the role of Ørnulv Ødegård at Gaustad Hospital in Oslo and the links between health authorities and the power élite in Norwegian psychiatry.

Keywords: *history; lobotomy; Norway; Ørnulv Ødegård; psychiatry*

Einar Kringlen (2004), in his presentation of 'A history of Norwegian psychiatry', totally neglects the role of Norway's leading post-war psychiatrist in the development of lobotomy/psychosurgery. Ørnulv Ødegård was the director of Norway's main mental hospital, Gaustad in Oslo, for 34 years from 1938 to 1972. Although 12 of his publications are included in Kringlen's reference list, none of them indicates his leading role in the development of this special field of psychiatric treatment. Such an omission creates a rather sanitized version of the sad realities of Norwegian lobotomy.

What were these realities? Annual reports from mental hospitals in Norway and Sweden and data received from hospital neurosurgical departments in Denmark reveal that Gaustad performed lobotomies earlier and in greater numbers than any other institution in Scandinavia: Gaustad 482 and Lier (also Norway) 373, compared with Sidsjøen (Sweden), Viborg and Sct. Hans (both Denmark) which performed almost 450 each (Tranøy, 1990, 1992, 1996). The development of lobotomy was sustained for twenty years by the efforts of

* *Address for correspondence:* (home) Rektorhaugen 47, 0876 Oslo, Norway. Email: joartranoy@hotmail.com

Gaustad and its director, and was influenced by links with American psychiatry – Ødegård had studied with Adolf Meyer (Retterstøl, 1980: 7). Ødegård's assistant, Carl W. Sem-Jacobsen, travelled to the USA to complete his own study of psychosurgery and established a psychosurgery project at Gaustad in the mid-1950s (Gaustad sykehus, 1957). Gaustad remained a centre for psychosurgery research until the 1960s, with financial support from the Ford Foundation and the United States Department of Defense (Gaustad sykehus, 1957: 6; Tranøy, 1992), and was the last Norwegian institution to stop using the practice in 1974. Records from a special file, the 'Test archive' at Gaustad Hospital, show that the last stereotactic operation was performed in that year, on an outpatient basis, on a woman from a psychiatric sanatorium (documents analysed in Tranøy, 1990, 1992).

Approximately 2500 persons were lobotomized in Norway (714 lobotomies per million inhabitants). In absolute terms, psychosurgery was most prevalent in the United States, with approximately 40,000 persons lobotomized, followed by Great Britain with approximately 17,000 and the three Scandinavian countries with a combined figure of approximately 9,300 (Pressman, 1986; Tooth and Newton, 1961; Tranøy, 1992; Valenstein, 1986).

According to the annual reports of the various medical institutions, lobotomies in Norway were usually performed in psychiatric hospitals rather than in the neurosurgical wards of general hospitals, as in Sweden and Denmark. Norway's geography may explain this difference. Indeed, transportation to centrally located hospitals with neurosurgical departments is more difficult than in either Denmark or Sweden. Because of this problem, itinerant surgeons with no training in neurosurgery often performed the operations. In western Norway, for instance, lobotomies were often done by itinerant orthopaedic surgeons (Wendelbo, 1989; see also Getz, 1956).

Medical periodicals, annual reports from Norway and Sweden, and data received from neurosurgical departments in Denmark show that Norway was also alone in Scandinavia in performing transorbital lobotomy. This operation, pioneered in the USA by Walter Freeman, consisted of forcing a solid, stainless steel ice-pick through the upper eye socket with a twisting movement. This produced an incision in the brain without the surgeon being able to observe directly the course of the incision. The method was so radical and primitive that even Freeman's partner, James W. Watts, distanced himself from it (Valenstein, 1986: 257). However, according to a report from one of the two Norwegian hospitals where transorbital lobotomy replaced the standard 'drill-and-scalpel' prefrontal method, it saved both time and money (Valen sjukehus, 1956: 2). Indeed, the new operation lasted only ten minutes, and the hospital was able to carry out 12 operations a morning as opposed to four as previously reported (Rimestad, 1956: 137). The method was even recommended by Ødegård (1953: 411) in the pages of *Tidsskrift for den Norske Lægeforening* (Journal of the Norwegian Medical Association), where he argued that it 'can be easily performed by the psychiatrist himself

with the tools he might have in his pocket, and strangely enough it may be harmless and effective'.

Mortality was especially high in the early years: 18 of the first 35 lobotomies on women resulted in the death (Tranøy, 1990: 7–8; 1992: 38). Almost all patients who died succumbed immediately after the operation. There is no reason to doubt that Norway's medical and public health authorities were aware of this high mortality rate. The medical staff at Gaustad and that of the National Health Authority (Helsedirektoratet) were very closely associated, and many of the leading doctors during that period, including the hospital's director, were alternately employed at Gaustad and the National Health authority (Tranøy, 1992, 1996).

In 1996 the Norwegian Parliament passed a temporary act of compensation that intended to offer the victims some restitution. This resolution came after a public debate following the publication of *Forfalskningen av lobotomiens historie på Gaustad sykehus* [The falsification of the history of lobotomy at Gaustad hospital] by the Department of Criminology, University of Oslo (Tranøy, 1990). A board of inquiry was appointed by the Ministry of Health, Professor Einar Kringlen being one of its members, and its investigative report (*Utredning om lobotomi*) was presented in 1992. It confirmed Tranøy's assertions about the number of patients lobotomized and, in particular, the operation mortality at Gaustad. Concerning Ødegård's role, the report concluded as follows (*Utredning om lobotomi*, 1992: 11):

The attitude of trendsetting individuals may be decisive for a development, especially in a non-homogeneous society like the Norwegian. The attitude of chief psychiatrist Ørnulv Ødegård can offer an explanation of why the use of lobotomy reached such an extent in Norway (*Utredning om lobotomi*, 1992: 11).

In his article, Kringlen (2004: 267) includes five completely sanitized lines on the Norwegian history of lobotomy, citing only one reference, of which he was co-author. Ethically, this omission of the full story is indefensible. Without the public attention being made aware of the falsification (Tranøy, 1990), no inquiry would have been undertaken.

A final point should also be made. Ødegård's part in the case of the Nobel Laureate Knut Hamsun is mentioned by Kringlen (2004: 266). Following a newly published biography (Kolloen, 2004), recent press discussions have hinted at a possible conspiracy between the psychiatrists and the government to avoid a scandalous court case, and instead nullify the literary icon Hamsun with the help of psychiatry.

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